

MEDICAL COSTS PEER REVIEW
STATEWIDE COORDINATING COMMITTEE
DEPARTMENT OF WORKERS' COMPENSATION

R E Q U E S T F O R P E E R R E V I E W

VWC File No. _____ Patient/Claimant_____

Applicant _____

Address _____

Complaint Against _____

Address _____

Nature of Injury or Occupational Disease_____

Date of Accident _____ Date Disability Began _____

Date of First Treatment _____ Date Disability Ended _____

Date of Last Treatment _____

Place of Treatment_____

Address_____

Specify each medical treatment, service, and/or cost to be reviewed and state the reason why you believe the charge is unwarranted. Supply copies of medical reports or documents which relate to and justify your request for Peer Review. Under "Basis for Request" specify whether cost of service is excessive, or treatment is otherwise inappropriate, and identify supporting document for each claim.

Service _____ Cost _____

Basis for Request_____

Service _____ Cost _____

Basis for Request _____

Service _____ Cost _____

Basis for Request _____

Service _____ Cost _____

Basis for Request _____

(if necessary, continue to another page using this same format)

You must supply us with documentation indicating what efforts you have made to resolve these matters before this Request will be referred for Peer Review.

Signature
of Applicant _____

Address _____

Telephone _____

Signed this _____ day of _____, _____.

Mail to: Medical Costs Peer Review Program
Virginia Workers' Compensation Commission
1000 DMV Drive
Richmond, Virginia 23220